REQUIREMENTS AND INSTRUCTIONS - PHYSICIAN (MD License) or PHYSICIAN employed by Hawaii State or County Government (MDG License)

Access this form via website at: **www.hawaii.gov/dcca/pvl**

This application is to be used by physicians seeking a regular physicians (MD) license or limited and temporary (MDG) license for Hawaii State or County government employment. Physicians seeking a limited and temporary license for education/teaching, sponsorship, or emergency/shortage are directed to use the "Limited and Temporary License - Physician" application form.

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MD LICENSE

This is a full, regular license that expires on January 31 each even-numbered year.

REQUIREMENTS MD LICENSE *(U.S. and Canadian* Medical Graduates*)*

U.S. and Canadian Medical School Graduates

- MD degree from an LCME-accredited medical school in the U.S. or Canada.
- One year of residency training in an ACGME-accredited program in the U.S. **OR**
  One year of residency training in an RCPSC or CFPC-accredited program in Canada.
- Satisfactory completion of the NBME, FLEX, USMLE, MCCQE (Qualifying Exam of LMCC) **OR**
  Satisfactory completion, prior to 2000, of an acceptable combination of the NBME, FLEX and USMLE **OR**
  Satisfactory completion of the SPEX, provided that the physician was licensed in another state by virtue of having passed a state-produced examination.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

REQUIREMENTS MD LICENSE *(Foreign* Medical Graduates*)*

Foreign Medical School Graduates (FMG)

There are two alternative pathways for FMG applicants.

FIRST PATHWAY:

- MD degree from a foreign medical school.
- Two years of residency training in an ACGME-accredited program in the U.S. **OR**
  Two years of residency training in an RCPSC or CFPC-accredited program in Canada
- Satisfactory completion of the NBME, FLEX, USMLE, MCCQE (Qualifying exam of LMCC) **OR**
  Satisfactory completion, prior to 2000, of an acceptable combination of the NBME, FLEX and USMLE **OR**
  Satisfactory completion of the SPEX, provided that the physician was licensed in another state by virtue of having passed a state-produced examination.
- ECFMG Certificate or MCCEE (Evaluating Exam of LMCC) **OR**
  Fifth Pathway Certificate.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- Verification of ECFMG or Fifth Pathway Certificate or MCCEE
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

(Continued on Back)

REQUIREMENTS MD LICENSE *(Foreign* Medical Graduates*)* (contd.)

SECOND PATHWAY:

- MD degree from a foreign medical school.
- Three years of medical training or experience in a hospital approved by the AMA's Council on Medical Education and Hospitals for internship or residency.
- Satisfactory completion of the FLEX or USMLE **OR**
  Satisfactory completion, prior to 2000, of an acceptable combination of these examinations.
- (As an alternative to the ECFMG Certificate), satisfactory completion, prior to 1984, of the VISA qualifying examination of the ECFMG.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of medical training or experience
- Verification of VISA qualifying examination of the ECFMG
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

****

MDG LICENSE

This is a limited and temporary license for government employment that expires on January 31 each year.

REQUIREMENTS MDG LICENSE *(U.S. And Canadian* Medical Graduates*)*

U.S. and Canadian Medical School Graduates

- MD degree from an LCME-accredited medical school in the U.S. or Canada.
- One year of residency training in an ACGME-accredited program in the U.S. **OR**
  One year of residency training in an RCPSC or CFPC-accredited program in Canada.
- Licensed by written examination in another state or U.S. territory.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- Verification of state or county government employment
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

REQUIREMENTS MDG LICENSE *(Foreign* Medical Graduates*)*

Foreign Medical School Graduates (FMG)

- MD degree from a foreign medical school.
- Two years of residency training in an ACGME-accredited program in the U.S. **OR**
  Two years of residency training in an RCPSE or CFPC-accredited program in Canada
- ECFMG Certificate **OR**
  Fifth Pathway Certificate.
- Licensed by written examination in another state or U.S. territory.

Items/documents required when applying:

- Application form
- Fees
- Verification of licensure
- Hospital affiliation form
- Evidence of MD degree
- Evidence of residency training
- Verification of ECFMG or Fifth Pathway Certificate
- Verification of state or county government employment
- National Practitioner Data Bank report
- AMA Profile
- Federation report
- Examination scores

INSTRUCTIONS FOR FILING AN APPLICATION AND SUBMITTING THE REQUIRED ITEMS

Type or print legibly in dark ink. Most items on the form are self-explanatory. Those that need explanation are discussed below.

FEES

ATTACH a check payable to: COMMERCE AND CONSUMER AFFAIRS

MD License issued between February 1, even-numbered year, to January 31, odd-numbered year, pay .....$ 290
(Application fee - $50**,License - $75, Compliance Resolution Fund - $90, ½ renewal - $75)

MD License issued between February 1, odd-numbered year to January 31, even-numbered year, pay.....$ 170*
(Application fee - $50**, License - $75, Compliance Resolution Fund - $45)

MDG License .....$ 120***
(Application - $25**, License - $50, Compliance Resolution Fund - $45)

* Subject to renewal January 31, even-numbered years – regardless of issue date.
** Application fee is not refundable.
*** Subject to renewal January 31, annually.

Note: *One of the numerous legal requirements you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a $15.00 service fee will be charged for checks which are returned by the bank.*

QUESTIONS

In the event the response to any of the questions numbered 5 through 9 is **"YES"**, please file a detailed explanation as directed on the application.

VERIFICATION OF LICENSE

On the application, list **all** the licenses you hold or held, including those for residency training or locum tenens.

ARRANGE to have verification of licensure sent **directly** to the BME. To do this, contact all the jurisdictions that you are/were licensed in and request that they send a verification of licensure **directly** to the BME.

HOSPITAL AFFILIATION FORM

On the application, list all the hospitals where (in the **last 3 years**) you:
- have held or applied for consultation, teaching appointments or privileges; or
- serve/served in a residency program.

ARRANGE to have hospital affiliation forms send **directly** to the BME. To do this, send copies of the attached "Hospital Affiliation" form (MD-08) to the hospitals and request that they send the forms **directly** to the BME.

EVIDENCE OF MD DEGREE

ATTACH a copy of your MD diploma, medical school transcripts or letter from the dean of the medical school, which provides the date of your graduation from medical school. If your documents are in a foreign language, an accurate translation must be attached.

EVIDENCE OF RESIDENCY TRAINING

The following applicants are to provide evidence of residency training:
- All U.S. and Canadian medical school graduates
- FMG applicants for MD license through 1st pathway
- FMG applicants for MDG license

ATTACH a copy of your residency certificate or letter from the program director of your residency training, which provides the dates of residency training.

EVIDENCE OF TRAINING OR EXPERIENCE

FMG applicants for MD license through 2nd pathway are to provide evidence of medical training or experience:

ARRANGE to have the hospital in which you received at least 3 years of medical training or experience send evidence of this **directly** to the BME. To do this, contact the hospital and request that they provide:
- hospital's name and address
- dates of your training or experience
- verification that the hospital has been approved by the AMA's Council on Medical Education and Hospitals for internship or residency

EVIDENCE OF ECFMG OR FIFTH PATHWAY CERTIFICATE

The following applicants are to provide evidence of the ECFMG or Fifth Pathway Certificate:

- FMG applicants for MD license through 1st pathway.
- FMG applicants for MDG license.

ECFMG Certificate

ARRANGE to have the Status Report of ECFMG Certification sent **directly** to the BME. To do this, contact ECFMG at (215) 386-5900 or go to www.ecfmg.org.

OR

Fifth Pathway

ARRANGE to have verification of completion of your AMA Fifth Pathway sent **directly** to the BME. To do this, contact AMA at www.ama-assn.org or call (312) 464-5199 for assistance.

VISA QUALIFYING EXAMINATION

FMG applicants for MD license through 2nd pathway are to provide evidence of medical training or experience:

ARRANGE to have ECFMG send the score of the VISA qualifying examination sent **directly** to the BME. To do this, contact ECFMG at (215) 386-5900 or go to www.ecfmg.org.

VERIFICATION GOVERNMENT EMPLOYMENT

All applicants for MDG license are to provide verification of government employment:

ATTACH a statement from an official of the state or county government agency confirming employment. This license is only valid for and while in the employment of the government agency.

NATIONAL PRACTITIONER DATA BANK REPORT

ATTACH the original "Response to Self-Query" report from the National Practitioner Data Bank (NPDB). To obtain the report, go to the NPDB website at www.npdb-hipdb.com and click on **Perform a Self-Query**. If you are unable to go on-line, call NPDB at 1-800-767-6732 for assistance. After you receive this report, send it to the Hawaii Board of Medical Examiners (BME).

AMA PROFILE

ARRANGE to have the American Medical Association (AMA) Profile sent **directly** to the BME by going to the AMA website at: www.ama-assn.org. Click on **Physicians**, then **Products and Services** and then on **Credentialing Products**. If you are unable to go on-line, call AMA at (312) 464-5199 for assistance. An AMA Profile is required of all physicians, including those who are not members of AMA.

FEDERATION REPORT

Applicants who passed the NBME or state examination:

ARRANGE to have the Federation Discipline Report sent **directly** to the BME. To do this, send the attached "Federation Discipline Report" form (MD-07) to the Federation of State Medical Boards (Federation) and request that they send the form **directly** to the BME.

Applicants who passed the USMLE, FLEX, or SPEX examination:

ARRANGE to have the Federation send an "Examination and Board Action History Report" (EBAHR) **directly** to the BME. To do this, call the Federation at (817) 868-4041 or go to their website at: www.fsmb.org and click on **Transcript Requests**. (The EBAHR also provides USMLE, FLEX, and SPEX examination scores.)

EXAMINATION SCORES

Applicants who passed the NBME examination:

ARRANGE to have the NBME examination scores sent **directly** to the BME. To do this, call the NBME Examinee Records office at (215) 590-9592 or go to their website at: www.nbme.org/programs/nbmecert.asp.

Applicants who passed the USMLE, FLEX, SPEX examination:

ARRANGE to have the Federation send an "Examination and Board Action History Report" (EBAHR) **directly** to the BME. To do this, call the Federation at (817) 868-4041 or go to their website at: www.fsmb.org and click on **Transcript Requests**. (The EBAHR also provides a board action history report.)

Applicants who passed a state-produced examination:

ARRANGE to have the state (where you took the examination) send the scores **directly** to the BME.

EXAMINATION SCORES (contd.)

Applicants who passed the MCCQE or MCCEE:

ARRANGE to have the Medical Council of Canada (MCC) send the scores or marks of the MCCQE or MCCEE **directly** to the BME. To do this, call the MCC at (613) 521-6012 or go to their website at: www.mcc.ca.

TO APPLY FOR EXAMINATION

TO APPLY FOR THE USMLE OR SPEX call the Federation at (817) 868-4041 or go to their website at: www.fsmb.org. USMLE applicants click on **USMLE**. SPEX applicants click on **Post-licensure Assessment**, then **Special Purpose Examination** (SPEX).

CERTIFICATION OF APPLICANT

Please read the certification at the end of the application and **sign and date it**.

RELEASE OF INFORMATION

If an agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete the portion on **Release of Information to Third Party**, sign and date it.

MAILING ADDRESS

APPLICATION AND ITEMS are to be:

Mailed to:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

OR

Delivered to:

Board of Medical Examiners
PVL
335 Merchant Street, Room 301
Honolulu, HI 96813

(Phone: 808-586-3000)

COMPLETE APPLICATION

We are unable to take action on an application unless it is complete. Therefore, please ensure that we have received all the documents necessary.

To do this, you may call (808) 586-3000 to inquire about the status of your application. If an agency is assisting with your application, we will release this information to them when you provide us with written authorization. (See Release of Information)

ABANDONMENT

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years; provided that the failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit the required documents and other information requested by the licensing authority within two consecutive years from the last date the documents or other information were requested, or (2) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process, including attempting to complete the examination requirement.

LICENSE DENIAL

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes.

Your written request for a hearing must be directed to the agency that denied your application (BME), and must be within 60 days of notification that your application for a license has been denied.

LICENSE RENEWAL

MD LICENSES expire on January 31 of each **even-numbered year**.
MDG LICENSES expire on January 31 **each year**.

About 2 months before the license expiration date, a renewal application is mailed to all licensees at their address of record. If you do not receive a renewal application approximately one month prior to the license expiration date, contact the Licensing Branch (808-586-3000) for assistance. To ensure that you receive a renewal application, keep the Board informed of your address. Licenses that are not renewed by the deadline are forfeited and the holders of a forfeited license are considered unlicensed and may not practice. After two years license forfeiture, reapplication is required.

LAWS AND RULES

The pertinent laws and rules are posted on our website free of charge at: www.hawaii.gov/dcca/pvl. Click on **Medical and Osteopathy**.

LAWS AND RULES (contd.)

Alternatively, you may obtain copies by sending a written request to: Licensing Branch, PVL, P.O. Box 3469, Honolulu, HI 96801.

1. Chapter 453, Hawaii Revised Statutes
2. Chapter 85, Hawaii Administrative Rules
3. Chapter 436B, Hawaii Revised Statutes

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

Application for License - PHYSICIAN (MD License) or PHYSICIAN employed by Hawaii State or County Government (MDG License)

Read instructions and requirements on attached sheet before completing this application.

Effective Date	License No.

FOR OFFICE USE ONLY

Circle type of license applying for: **MD** **MDG**

Legal Name (First-Middle)	(Last)

Residence Address (include apt. no., city, state and zip code)

Mailing Address (**ONLY** if different from above)

Social Security No.	Phone No. (days)

Other names used	Birth date:

Circle answers:

1) Are you at least 18 years of age? ..... YES NO
2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the U.S.? ..... YES NO
3) Are you a graduate of a **U.S. or Canadian** medical school? ..... YES NO
4) Are you a graduate of a **Foreign** medical school **(FMG)**? ..... YES NO

Circle answers and **provide details** as directed for any "yes" response to the questions below:

5) Have you ever held a license in Hawaii? ..... YES NO
If response "yes," specify type of license and dates below:

6) With regard to any medical license to practice in any state or country:
   a) Has it ever been revoked, suspended, placed on probation, surrendered, reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement? ..... YES NO
   b) Is any disciplinary action pending against you? ..... YES NO
   c) Are you presently being investigated? ..... YES NO
   d) Have you ever been denied a license or withdrawn an application for licensure? ..... YES NO

   If response "yes," attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action.

7) With regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards:
   a) Have you ever been subject to disciplinary or adverse actions or entered into an agreement? ..... YES NO
   b) Is any disciplinary or adverse action pending against you? ..... YES NO
   c) Are you presently being investigated? ..... YES NO
   d) Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership? ..... YES NO

   If response "yes," attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction or organizations involved, relevant dates, action taken and reasons for such action.

8) With regard to professional liability:
   a) Have any claims of malpractice ever been filed against you? ..... YES NO
   b) Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage? ..... YES NO

   If response "yes," attach a detailed explanation on a separate sheet, which:
   - *includes the date of the case (month/year), jurisdiction (State, etc.) nature of the case, allegations, and amount paid on your behalf. Information is to be provided on all settlements, judgments, awards, and claims (including those for which no money was paid); and/or*
   - *provides the name and address of your insurance carrier, specific circumstances, date and action taken.*

(Continued on Back)

End:	App/Lic	323/312	$50/$75
Gov:	App/Lic	323/312	$25/$50
	CRF	324	$45/$90
	½ Ren	300	$ 75
	Service Fee	BCF	$ 15

9) With regard to participation in any health plan or Federal or State health care program:
   a) Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation? ..... YES NO
   b) Have you ever been convicted of insurance fraud? ..... YES NO

If response "yes," attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction relevant dates, allegations, charges, disposition, action taken and reasons for such action.

10) In the past five years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects? ..... YES NO

If response "yes," attach a detailed explanation on a separate sheet.

11) During the past twenty years, have you been convicted of a crime in which the conviction has not been annulled or expunged? ..... YES NO

Explain "yes," response on a separate sheet with detailed information and attach supporting documents.

LICENSES	Name of Jurisdiction	Date Issued	License Number		Date Verification Requested	
AFFILIATION	Hospital Affiliation (If none, state "None") Name of Hospital	Location (City/State or Country)	Dates (mo/yr) From	 To	Date Form Requested	
EDUCATION	Name of Medical School	Location (City/State or Country)	Degree Earned		Dates (mo/yr) From	 To
RESIDENCY	Name of Residency Program	Location (City/State or Country)			Dates (mo/yr) From	 To
TRAINING/ EXPERIENCE	Training or Experience Name of Hospital	Location (City/State)	Dates (mo/yr) From	 To	Date Verification Requested	

CERTIFICATION OF APPLICANT:

I certify that all the information contained on this application and the supporting documents submitted are true and correct. I understand that this certification and any misrepresentation are grounds for the denial or subsequent revocation of a license.

Signature of Applicant

Date

Release of Information to Third Party:

To assist me in the licensing process, I authorize the BME and staff to release any and all information regarding my application (including but not limited to, application status, examination scores, disciplinary or criminal history, National Practitioner Data Bank Report, AMA Profile) to:

Name of Individual who is assisting you: _____

Name of Organization: _____

Address of Organization: _____

_____

_____

_____ _____

Signature of Applicant Date

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

FEDERATION DISCIPLINE REPORT - PHYSICIAN

Access this form via website at: **www.hawaii.gov/dcca/pvl**

TO THE APPLICANT: All applicants who passed the NBME are required to provide completion of this report by the Federation of State Medical Boards.

Complete the APPLICANT section and mail this form to:

Federation of State Medical Boards
P.O. Box 619850
Dallas, TX 75261-9850
Phone: (817) 868-4000

APPLICANT

LAST NAME, First, Middle	Social Security No.	Birthdate

Medical School of Graduation & Branch Location	Date of Graduation

I authorize the Federation of State Medical Boards to indicate on this form if there is any previous or pending disciplinary action against my licenses in any state.

Date _____ _____

Signature of Applicant

FEDERATION

TO THE FEDERATION: Please indicate below if there is any previous or pending disciplinary action against any licenses of the above-named individual.

Signature _____

Title _____

Date _____

PLEASE RETURN THIS FORM **DIRECTLY** TO THE HAWAII BOARD OF MEDICAL EXAMINERS AT THE ADDRESS BELOW:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

HOSPITAL AFFILIATION – PHYSICIAN

Access this form via website at: **www.hawaii.gov/dcca/pvl**

TO THE APPLICANT: Complete the *"Applicant"* section of this form. Send a form to each hospital where you have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency during any part of the most recent **3 years** preceding your application for a physician's license in Hawaii. Your residency program director may complete this form in place of each hospital's administrator. If more than one form is needed, please duplicate both sides.

APPLICANT

Name (First-Middle)	(LAST)	Social Security No.	Birthdate

Date Served/Applied:	Capacity Served or Applied for	Name of Hospital/Residency Program

To: CHIEF OF STAFF, ADMINISTRATOR OF HOSPITAL OR RESIDENCY PROGRAM DIRECTOR

I am applying for a license to practice medicine and surgery in Hawaii. The board requires this form be completed by the Chief of Staff or Administrator in each hospital where I have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency. For my residency program, the program director may complete this form. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.

This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii State Board of Medical Examiners in connection with my application. Please complete the following questionnaire, SUPPLY COPIES OF INFORMATION IN YOUR RECORDS that would provide further information and **return the material directly to the address on the reverse side**.

Date _____ _____

Signature of Applicant

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

NOTE: This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

Please complete A and C or B and C as applicable

A. **POSTGRADUATE TRAINING:**

1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ..... YES NO
2. Briefly evaluate applicant's competence and conduct during the program: _____
3. Has the program ever had cause to restrict, suspend, terminate, or ask for a voluntary resignation of applicant's participation in the program? ..... YES NO
   If response "yes," please explain and attach copies of material from your records: _____

B. **HOSPITAL PRIVILEGES:**

1. Were privileges extended to the applicant? ..... YES NO
2. Please describe privileges: _____
3. Was applicant rejected privileges? ..... YES NO
   If response "yes," please explain and attach copies of material from your records: _____
4. Were privileges ever limited, revoked, suspended or restricted? ..... YES NO
   If response "yes," please explain and attach copies of material from your records: _____

C. **SAFE PRACTICE COMMENTS:**

1. Is there anything in your files which could call into question applicant's ability to safely practice medicine? ..... YES NO
   If response "yes," please explain: _____
2. Derogatory information, if any: _____

(CONTINUED ON BACK)

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Date _____

_____
Signature of Chief of Staff, Administrator or Program Administrator

Name _____

Title _____

HOSPITAL/PROGRAM SEAL
(If none, please so indicate.)

Hospital/Residency Program _____

Address _____

_____

Phone No. ( ) _____